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Letters...

Catholic Physicians' Guild

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Letter from Ireland, 1982

A survey of population trends among the members of the European Economic Community reveals that Ireland is the only country with an increasing number of citizens. The population of all Ireland now stands at 5 million, and 3.4 of these live in the Irish Republic. While the population of the North of Ireland has remained virtually unaltered, the Southern portion has sustained an increase of 15% or 45,000 in the past 10 years. This allows for a birth rate of 21 per 1,000 with an associated death rate of less than 10 per 1,000. While these statistics may seem impressive, there has in fact been little change in the reproductive habits of the Irish for many generations. To explain, since the great famine of the 1840s, we have always maintained our population level by emigration to such places as the United States of America, Great Britain and her erstwhile colonies. This habit ceased in the 1960s, when the government of this country made great efforts to industrialize and thus to encourage young people to work at home. In recent years we have even had a return of some Irish from abroad with their families for this reason. There has also been a continuous drift from the land to the cities in the East. While this has naturally been a great challenge to the planners, it has also altered the traditional standards of an erstwhile rural population. All this would have caused little notice if the present recession had not occurred. With the boom of the late 1960s and early 70s, people had married at a younger age and began to raise families that are now of the age when they are most expensive to maintain, or are a little older and looking for work. This has led to an increased interest in family planning with one direct result being the raising of the ban on the import of contraceptives, but we discussed this in another letter. However, with nearly 4,000 Irish women per annum going abroad for abortion, we have reached a new stage in our moral dilemma. Now the Constitution of Ireland respects the unique position of the Catholic Church and the sanctity of human life, and consequently we have no abortion. I might add we are the only country in the E.E.C. whose constitution and laws are such. With changing morals and relaxation of the attitudes of an earlier generation, demands are being made by certain groups for permission for abortion. This is naturally a great source of worry to our hierarchy and to the great proportion of Christian people in this country. If this were to succeed, we would soon have abortion on demand, like our neighbors. During the election campaign last year, the present government promised that it would hold a referendum to establish the country's attitude to abortion, or more positively, to alter the Constitution to guarantee the rights of the unborn child. The media have had months of discussion on this matter and all opinions have been canvassed. The hierarchy have said they will speak when the text of the referendum bill is published. This referendum may well be held next spring. Certainly our overseas abortion rate is high and our unmarried mother percentage is high also, but the legalization of abortion will hardly alter these problems. Catholic medical groups naturally wish to protect the unborn child, but the final decision will be made by the people at the polls.

This year we celebrated the 21st anniversary of the formation of the Irish Medical Union. This was a breakaway from the Irish Medical Association with particular interest in conditions of service and remunerations, contracts, etc. Over the years the Medical Union has achieved not only many concessions and agreements on behalf of the profession, especially the family doctors, but also a common contract

for the specialists in state hospitals, which we discussed last year. The value of this service becomes more obvious day by day and especially now when all state spending is being reduced due to the recession, with even established medical services under review. However, it has been realized that a medical population of only about 9,000 would hardly need two bodies both interested in the protection of the doctor. We are thus pleased to hear from the newly-elected president of the Medical Union that he hopes to be the last man to hold this office, and will complete the reunification during this year. We naturally wish him every success.

To finish with a news item. Plans have been announced to establish a super hospital-clinic outside Dublin to cater to the very rich. These latter, who had normally gone to the private clinics in London, are now finding it too expensive. The company will be backed by American-Canadian interests and will be staffed by Irish specialists. Certainly even our ordinary Irish private hospitals and nursing homes can hardly survive without our Voluntary Health Insurance, which is rather similar to the Blue Cross, because of rising costs. Therefore, one can understand this plan, although one wonders how soon it will catch up with the expenses of our neighboring country.

— **Dr. Robert F. O'Donoghue**
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Re: Cerebral Death

To the Editor:

I write to comment on Dr. Colin Harrison's lengthy letter on the topic, "Cerebral Death," which appeared in the November, 1982 issue of the *Linacre Quarterly*. While appreciating both the concerns and the sentiments expressed in that letter, I fear that Dr. Harrison has inadvertently misquoted a journal article and a court opinion in arguing against the concept of brain death and of courts intervening in such matters.

In quoting from Sheila Taub's article on brain death which appeared in *Connecticut Medicine*, Dr. Harrison stated that the author gave three reasons for "*treating* the irreversibly unconscious patient" (my emphasis). A review of that article (vol. 45, pp. 597-599) shows that Ms. Taub made a statement which is, in fact, much more consistent with Dr. Harrison's concerns that the treatment of patients not be inappropriately prolonged when, as he put it, "any hope of curative treatment has long since been lost." Ms. Taub wrote (at pp. 598-599):

"Patients who meet any of the accepted criteria of brain death are destined to lose all bodily functions within a matter of weeks, regardless of the care provided to them. *The advantages of declaring the patient dead when brain death is observed* [my emphasis], rather than waiting for the cessation of respiration and circulation to occur, are that: 1) the patient's organs become available for transplantation while they are still in the optimum condition; 2) the patient's relatives are spared the emotional and financial burdens of treating the patient as if he/she were still alive for several additional weeks, when death is inevitable; and 3) society is spared the use of scarce and expensive resources which can be more profitably used on other patients."

Dr. Harrison also makes the statement in his letter that:

"In the Quinlan case, the court ruled, 'He (the physician) must do *all* [Dr. Harrison's emphasis] in his human power to favour life against death.' 'All.' There is no choice. There are no exceptions."

Searching for that quotation, I found its probable source in the opinion of the trial judge, Judge Robert

Muir, Jr. of the Superior Court of New Jersey, Morris County, who did write in his opinion (which can be found in the two-volume collection of *Quinlan* case materials titled *In The Matter of Karen Quinlan* [University Publications of America, 1975] at vol. I, pp. 540-568, the quoted reference below appearing on p. 559):

"There is a higher standard, a higher duty, that encompasses the uniqueness of human life, the integrity of the medical profession and the attitude of society toward the physician and therefore the morals of society. A patient is placed, or places himself, in the care of a physician with the expectation that he (the physician) will do everything in his power, everything that is known to modern medicine, to protect the patient's life. He *will do* [my emphasis] all within his human power to favor life against death [with a footnoted reference to a book by Epstein, *The Role of the Physician in Prolongation of Life, Controversies in Medicine II*, Saunders & Co., 1973]."

There is, in my opinion, a big difference between the words, "must" and "will." There is an even bigger difference between a trial judge's opinion and the opinion of a state's highest court. The *Quinlan* case was decided finally by the Supreme Court of New Jersey; the trial court opinion was binding on no one after the case went up on appeal to the Supreme Court. Did the Supreme Court of New Jersey rule that every physician had to do everything possible to keep every patient alive and must never discontinue treatment?

No! The court went out of its way to make a point, again consistent with Dr. Harrison's views, that may not be familiar to many readers, but bears repeating. The court stated [at vol. II, p. 310, of the earlier-cited materials on the *Quinlan* case and, for those who like legal references, 355 *Atlantic Reporter*, 2nd series 647, at p. 667 (1976)]:

"We glean from the record here that physicians distinguish between curing the ill and comforting and easing their dying; that they refuse to treat the curable as if they were dying or ought to die, and that they have sometimes refused to treat the hopeless and dying as if they were curable. In this sense, as we were reminded by the testimony of Drs. Korein and Diamond, many of them have refused to inflict an undesired prolongation of the process of dying on a patient in irreversible condition when it is clear that such 'therapy' offers neither human nor humane benefit. *We think these attitudes represent a balanced implementation of a profoundly realistic perspective on the meaning of life and death and that they respect the Judeo-Christian tradition of regard for human life. No less would they seem consistent with the moral matrix of medicine, 'to heal,' very much in the sense of the endless mission of the law, 'to do justice'* [my emphasis]."

The court goes on to recognize the potential fears of malpractice suits and criminal prosecutions which have troubled some physicians in implementing these goals and finally states its preference that health care decision-making be controlled primarily within the patient-doctor-family relationship without applying to courts for confirmation of such decisions. As the Supreme Court noted, requiring judicial confirmation of each such medical decision "would be a gratuitous encroachment upon the medical profession's field of competence . . . [and] impossibly cumbersome" (at p. 312 of vol. II, and 355 A.2d at 669).

I apologize for the lengthy reply, but my purpose is not to make nitpicky criticisms of Dr. Harrison's skill in quoting from various sources. The issue is far more important.

This journal has featured a number of critiques of the brain death concept (the latest article being R. Mary Hayden's article, "A Philosophical Critique of the Brain Death Movement," in the August, 1982 issue), and there is an apparent hostility to this concept, not to mention a shrillness of tone, that troubles me.

In other publications, I have railed

against the inappropriate intervention by courts into such medical decisions as Dr. Harrison so properly discusses. I am of the belief, however, that finding fault with brain death statutes, or even with the very concept of brain death, is distracting us from understanding its very humane features when properly and conscientiously applied to a specific patient who meets the criteria. As the *Quinlan* case so well demonstrates, medical technology has the potential of prolonging the dying process and causing suffering of many different dimensions. Ventilators, dopamine drips, hemodialysis machines, wide-spectrum antibiotics and other tools of the critical care unit all have their positive and very proper roles, but their utilization on patients who have irreversibly lost total brain function (both neocortical and brain stem) seems questionable at the least and obscene at worst. Death is not an evil to be fought off at all costs, as so many in this society seem to feel. As the *Declaration on Euthanasia* of the Sacred Congregation for the Doctrine of the Faith, issued in 1980, stated:

"Life is a gift of God, and on the other hand death is unavoidable; it is necessary therefore that we, without in any way hastening the hour of death, should be able to accept it with full responsibility and dignity. It is true that death marks the end of our earthly existence, but at the same time it opens the door to immortal life. Therefore all must prepare themselves for this event in the light of human values, and Christians even more so in the light of faith."

Yes, there are legitimate concerns about the dangers of hastening death and the inappropriate use of brain death criteria, but similar concerns can be raised about almost every facet of medical care. It is precisely the use of the ventilator that has caused the need for the concept of brain death; no one is suggesting that ventilators never be used in the treatment of patients.

As Dennis Horan, Esq., a member of this journal's editorial advisory board, has written in his monograph, "Euthanasia and Brain Death: Ethical and Legal Considerations" (*Americans United for Life Studies in Law and Medicine*, no. 1, at pp. 18-19):

"As in the case of abortion, to open the door and legalize mercy killing in one case is to legalize it in a full range of cases that are never contemplated by the progenitors of the policy. For these reasons even what appears as a small inroad into the creation of this policy, named cerebral death, it must be opposed. *However, if the irreversible cessation of total brain function is really death, which it appears to me and to most observers that it is, then such a concept can be supported without creating the dangers of which I have spoken*" [my emphasis].

The most authoritative and current criteria for determining brain death were published by the President's Commission for the Study of Ethics in Medicine and can be found in *JAMA*, vol. 246: 2184 (1981). The Law Reform Commission of Canada in 1981 made recommendations to the Canadian Parliament for a brain death statute which makes no attempt to state clinical criteria or guidelines. Medicine, the Commission said, will determine the content of the standard of brain death, based on new scientific understanding from time to time. The American Medical Assocation and other groups have endorsed a Uniform Determination of Death statute which many state legislatures have adopted or are now considering.

Without losing sight of potential abuses, we can both support the brain death concept as carefully defined and applied to specific patients, and further the care of patients as Dr. Harrison so rightly suggests.

Sincerely,
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